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IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1978

HELEN B. O'BANNON, SECRETARY OF
PUBLIC WELFARE, PENNSYLVANIA, PETITIONER

v.

TOWN COURT NURSING CENTER, ET AL.

ON WRIT OF CERTIORARI TO
THE UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

BRIEF FOR JILL HARRIS AND THE RESIDENTS OF EDGEFIELD MANOR IN SUPPORT OF RESPONDENTS

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Aptheker v. Secretary of State, 378 U.S. 500 (1964) 42

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Franceschina v. Morgan, 346 F. Supp. 833 (S.D. Ind. 1972). 44-45

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Kane v. Parry, 88 Misc.2d 1019, 371 N.Y.S.2d 605, rev'd, 390 N.Y.S.2d 191, 55 App. Div. 678, rev'd, 41 N.Y.2d 1051, 396 N.Y.S.2d 182, 364 N.E.2d 846 (1977) 27

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McLaughlin v. Tilendis, 398 F. Supp. 315 (N.D. Ga. 1971). 44

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Poe v. Ullman, 367 U.S. 497 (1961) 53

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Roe v. Wade, 410 U.S. 113 (1973) . . . .38-40, 52-53, 54, 2-1 to 2-2

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Schaak v. Schmidt, 344 F. Supp. 99 (E.D. Wis. 1971). 32-33

Smith v. Vowell, 379 F. Supp. 139 (W.D. Tex. 1974), aff'd, 504 F.2d 759 (5th Cir. 1974) 33

Smith v. Organization of Foster Families for Equality & Reform, 431 U.S. 816 (1977) 47-49

Sniadach v. Family Finance Corp., 397 U.S. 337 (1969). 34

Stanton v. Bond, 504 F.2d 1246 (7th Cir. 1974) 31, 32, 33

Stitt v. Manor Care, Inc., CCH Medicare & Medicaid Guide, ¶ 29,409 (N.D. Ohio, Oct. 24, 1978) 27-28, 35

T.H. v. Jones, 425 F. Supp. 873 (D. Utah 1975) 32, 33

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United Mine Workers of America, District 12 v. Illinois State Bar Association, 389 U.S. 217 (1967) 43-44

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Wood v. Davison, 351 F. Supp. 543 (N.D. Ga. 1972). 51

Wyandotte Transportation Co. v. United States, 389 U.S. 191 (1967) 65, 78

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42 U.S.C. § 1396a(a) . . . . . 1, 5, 20, 22, ... 56-61, 81

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42 C.F.R. § 449.12 . . . . 1, 5, 29, 31, 64

45 C.F.R. § 205.10 . . . 21-22, 33, 59 & n.1

- Other Materials -

Aldrich, Personality Factors and Mortality in the Relocation of the Aged, 4 Gerontologist 92 (1964). . . . . 2-22, 2-27 to 2-28

Aldrich and Mendkoff, Relocation of the Aged and Disabled: A Mortality Study, 11 J.Am. Geriatrics Society 185 (1963) . . . . . 2-3 to 2-4, ... 2-6 to 2-7, 2-27

Blenkner, Environmental Change and the Aging Individual, 7 Gerontologist 101 (1967) 2-27

Bourestom and Tars, Alterations in Life Patterns Following Nursing Home Relocation, 14 Gerontologist 506 (1974) . . . . 2-5, 2-7, ... 2-13 to 2-14, 2-18 to 2-19, 2-32

Bourestom, Pastalon, and Tars, Relocation Report No. 2, Death and Survival (Institute of Gerontology, University of Michigan-Wayne State U. 1972?) . . . . 2-14 to 2-15, 2-21 to 2-22

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Brand & Smith, Life Adjustment and Relocation of the Elderly, 29 J. of Gerontology 336 (1974) . . . . . 2-19 to 2-20

Brody, Kleban and Moss, Measuring the Impact of Change, 14 Gerontologist 299 (1974) 2-5

Goldfarb, Fisch, and Gerber, Predictors of Mortality in the Institutionalized Aged, 27 Diseases of the Nervous System 21 (1966) . . . . . 2-20 to 2-21

Gutman and Herbert, Mortality Rates Among Relocated Extended-Care Patients, 31 J. of Gerontology 352 (1976) . . . . . 2-5, 2-17 to 2-18, ... 2-23, 2-32

Jasnau, Individualized Versus Mass Transfer of Non-Psychotic Geriatric Patients from Nursing Homes, With Special Reference to the Death Rate, 15 J.Am. Geriatrics Society 280 (1967) 2-6

Kahn and Kaplan, Phase-Out of Grafton State Hospital, Interim Report 15 (Mass. Dept. Mental Health 1974). . 2-5, 2-10 to . . . . . 2-11, 2-15 to 2-16

Killian, Effect of Geriatric Transfers on Mortality Rates, 15 Social Work 19 (1970) . . . . 2-6, 2-7, ... 2-9 to 2-10, 2-21, 2-22

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Kral, Grad, and Berenson, Stress Reactions Resulting from the Relocation of an Aged Population, 13 Canad. Psychiat. Ass. J. 201 (1968) . . . . . 2-6, 2-23, 2-25 to 2-26

Lieberman, Relocation Research and Social Policy, 14 Gerontologist 494 (1974) . . . . . 2-8, 2-11 to 2-13, 2-22, ... 2-28 to 2-29, 2-33

Markus, Blenkner, Bloom and Downs, Some Factors and Their Association With Post-Relocation Mortality Among Institutionalized Aged Persons, 27 J. of Gerontology 376 (1972) 2-6, 2-23

Novick, Easing the Stress of Moving Day, 41 Hospitals, J.A.H.A. 64 (1967) . . . 2-5, 2-16 to 2-17, ... 2-24 to 2-25, 2-29 to 2-31

INTEREST OF AMICI

Both Jill Harris and the Residents of Edgefield Manor are appellants in cases pending before the United States Court of Appeals for the Ninth Circuit; both assert that the trial court erred in refusing to recognize their rights, as title XIX nursing home residents, to hearings prior to involuntary transfers.

Jill Harris is plaintiff and appellant in JILL HARRIS vs. ROSE HAVEN, INCORPORATED, 9th Cir. No. 78-1846. She appeals from an order denying a preliminary injunction to forbid her transfer absent a hearing at which she could contest the provider's determination that a transfer was for "medical reasons or for [her] welfare" (42 C.F.R. § 449.12(a)(1)(ii)(B)*(4)*), and at which she could demonstrate that the transfer is contrary to her best interests in violation of 42 U.S.C. § 1396a(a)(19).

The Residents of Edgefield Manor are certified as class plaintiffs and are the appellants in ALTA BUMPUS, et al., vs. DONALD E. CLARK, et al., 9th Cir. No. 77-2883. They commenced the action as a result of the announcement of Multnomah County, Oregon, that their county-run nursing home would be closed and all residents transferred. The Residents of Edgefield Manor assert that a variety of regulatory, statutory, and constitutional provisions limit the county's ability to subject them to life-threatening transfers. Even if the county may, under some circumstances, transfer the residents, the residents contend that they must be afforded individual hearings to determine whether a transfer is consistent with the "best interests" requirement in each case, or at least to ensure that each transfer is arranged consistently with each resident's best interests in terms of medical needs,

visitation opportunities, and associations with other residents and staff.

As a practical matter, this Court's disposition of Town Court may well determine the fate of amici's appeals, and, in turn, whether the Residents of Edgefield Manor will have to endure involuntary transfers. As Jill Harris alleged, and as the Residents of Edgefield Manor proved through massive and uncontradicted expert testimony, an involuntary transfer may well prove deadly to as many as half of them.

Accordingly, the interest of amici is that their very lives may be at stake.

STATEMENT OF THE CASE

Although the facts of amici's cases are not otherwise of record before this Court, those facts dramatically illustrate both the interests typically affected by any involuntary transfer of a nursing home resident, and the fact issues inherently

critical to every determination of whether to precipitate or to permit such a transfer. Since this Court's resolution of the legal issues in Town Court will necessarily affect the hearing rights of Medicaid recipients in circumstances like those of amici, amici submit that it is appropriate to relate those circumstances to this Court.

A. JILL HARRIS

Jill Harris resided at Rose Haven Nursing facility as an Intermediate Care Facility (ICF) Medicaid recipient. Throughout her stay there, she received visits at least daily from her husband or from her daughter or son-in-law, who had relocated to Roseburg, Oregon, when Mrs. Harris first became ill. Mrs. Harris also received visits from church friends several times each week.

In March of 1978, Rose Haven determined that caring for Mrs. Harris was

causing "excessive" demands on its staff, and asked the state Welfare Division to arrange a transfer to a Skilled Nursing Facility (SNF). Committed to the position that no notice or hearing rights exist, the Welfare Division arranged to transfer Mrs. Harris to a SNF in Coos Bay, Oregon, some 2-1/2 hours away from her friends and relatives in Roseburg. The Coos Bay facility was undergoing decertification proceedings for patient care violations at the time. The proposed transfer was aborted by the filing of Harris v. Rose Haven.

In that case, Mrs. Harris contended that she was entitled to a hearing before any involuntary transfer, and that the transfer was not for her welfare as required by 42 C.F.R. § 449.12(a)(1)(ii)(B)(4) and contrary to her best interests in violation of 42 U.S.C. § 1396a(a)(19).

Treating the plaintiff's application for a temporary restraining order as a motion for preliminary injunction, the trial court heard testimony by telephone conference call. The doctor, who one day prior to the filing of the lawsuit had written a letter stating that Mrs. Harris' care at Rose Haven was "adequate," testified that a transfer to a skilled facility was necessary because she needed almost continuous monitoring, that she required a nurse call device she could operate, and that she needed heavy medical care.

On cross examination, however, the doctor conceded that he was ignorant of which services and personnel were required of an intermediate care facility and which were available only at a skilled facility, that he was unfamiliar with transfer trauma, and that he was unaware of the extent to which plaintiff's family members contributed to her physical therapy. He also acknowledged

that her family's visits were "very helpful to her" and that the transfer would be emotionally traumatic.

Rose Haven's director of nursing testified that the facility sought the transfer because caring for Mrs. Harris caused excessive demands on the staff, because of the nursing call device, and because Mrs. Harris needed whirpool therapy five days a week instead of three -- a need not identified by the doctor.

The Manager of the state welfare program responsible for nursing homes testified that of all the needs identified by the doctor and Rose Haven's director of nursing, none justified a transfer other than the need for whirlpool therapy five days a week. The Manager explained that the call light should be the same at an ICF as at a SNF, and that all of the identified needs were required to be met at an ICF except the five days of whirlpool

therapy. She also testified that most doctors were ignorant of the distinctions between ICF and SNF care requirements.

The trial court agreed that only whirpool therapy justified the transfer, and denied the preliminary injunction. Two days later, the defendants arranged for Mrs. Harris' transfer to a SNF 96 miles from her home community -- even though the home they selected had no whirlpool facilities. It subsequently came to light that the state agency had discontinued whirlpool therapy authorization as contraindicated for Mrs. Harris well before the intitial transfer decision.

Mrs. Harris has contended throughout the litigation that the real reason for her transfer -- and that of four others -- was that Rose Haven wanted to rid itself of heavy care patients to maximize its profit, even though SNF-level care was unnecessary. See Appendix 1 (letter from

Rose Haven: "Any welfare patient that requires an excessive amount of nursing staff time will be transferred . . ."].

Mrs. Harris' appeal from the order denying the preliminary injunction has been briefed before the Ninth Circuit Court of Appeals. No argument date has been set.

B. THE RESIDENTS OF EDGEFIELD MANOR

Edgefield Manor is a title XIX Intermediate Care Facility owned and run by Multnomah County. For many years, Edgefield Manor has been one of the best nursing homes in Oregon. In February of 1975, the county announced plans to close the facility and to move the residents into private homes throughout the state. By spring of that year, however, the county rescinded the announcement when its plans went awry: the private nursing home operator who figured prominently in the

plans was found to have committed fraud in obtaining his state license, and Edgefield staff voiced growing alarm at the numbers of residents who were dying or falling ill in apparent response to the impending closure.

When the county renewed its closure plans in early 1976, and Edgefield staff again reported apparently related mortality and morbidity among residents, the residents filed Bumpus v. Clark, contending that a variety of constitutional and title XIX provisions entitled them to prevent life-threatening transfers, or at least entitled them to hearings prior to transfers -- either to resolve whether involuntary transfers were permissible or to determine the rights of each resident to accommodation of individual needs for medical services, proximity to regular visitors, and retention of critical relationships with staff and other residents.

The Residents of Edgefield Manor based their contentions upon associational interests, rights of privacy, the due process protection of life and liberty, title XIX best interest requirements and regulatory transfer limitations, and both due process and regulatory hearing rights.

The case was resolved at the trial level on the motions of the state and county defendants to dismiss the action and on the plaintiffs' cross motion for partial summary judgment.

In support of summary judgment, the Residents of Edgefield Manor presented the results of substantial discovery. In addition to affidavits from residents, their friends and relatives, staff members, and a psychiatric consultant, the plaintiffs presented depositions of county and state officials, Edgefield's administrator, and the doctor most familiar with Edgefield's residents, as well as an extensive

deposition of the county's transfer trauma expert responsible for minimizing the harm to be caused by the move. In the latter deposition, the expert discussed most of the existing literature on transfer trauma, and explained the testing he administered to determine the risk of transfer to the residents. Plaintiffs also presented affidavits of national transfer trauma experts commenting on the risks and on the results of the county expert's tests. Finally, the plaintiffs presented a summary of transfer trauma literature.

The state and county defendants made no attempt to dispute the plaintiffs' showing of the nature, source, and extent of harm a transfer would threaten; the county's expert essentially agreed with the residents' position on the facts. The trial court dismissed on the theory that it was without power to prevent the harm the plaintiffs proved would accompany a transfer.

What follows is a description of the uncontroverted evidence offered by the Residents of Edgefield Manor, as it relates to the issues before this Court. Appendix 2 is a summary of the transfer trauma literature similarly edited.

The Residents of Edgefield Manor have replaced the family and community relationships of the outside world with a social fabric consisting of long-standing and family-like relationships with staff and other residents. Although some are still fortunate enough to enjoy regular visits from relatives, most are heavily dependent for their medical and psychological well being upon relationships they have built up within the institution -- relationships which are fully equal in emotional significance to parent-child and/or sibling relationships, depending upon the physical and cognitive condition of each resident.

The relationships enjoyed by the residents are critical to their ability to preserve a sense of dignity and privacy, particularly for those who are incontinent or otherwise dependent upon staff members for personal hygiene. It is the loss of such relationships which is apparently the major factor in the phenomenon known as transfer trauma.

As set forth more fully in Appendix 2, "transfer trauma" describes the correlation between transfers of institutionalized elderly and dramatic increases in death rates and illness among those transferred. The county's expert studied the literature on transfer trauma and administered a series of tests to ascertain the residents' chances of surviving a transfer in view of the physical and cognitive conditions which correlate with high death rates in the existing transfer studies. The tests reflected that the residents were infirm,

elderly, and variously afflicted with heart disease, stroke disorders, chronic brain syndrome, incontinence, cognitive impairment, and other disabilities which render them extremely vulnerable to death as the result of an involuntary transfer. The expert concluded that 75% of the residents were "at high risk" in terms of their vulnerability to transfer trauma, and projected over a three-fold increase in mortality within three months following a move.

As noted in Appendix 2, mortality rate increases to eight or nine times normal have been recorded. Professor Morton Lieberman, whose studies form a substantial portion of the existing literature, reviewed the county expert's test results. Professor Lieberman agreed that the high risk patients were correctly identified by the tests, and submitted an affidavit expressing the opinion that

transferring nursing home residents with such physical and cognitive impairments "entails a mortality risk of over 50 percent."

The evidence produced by the Residents of Edgefield Manor proved without contradiction that an involuntary transfer without the staff might well kill one third to one half of those residents. The doctor familiar with the residents predicted, based upon his previous experience with transferred nursing home residents, that ambulatory patients would become bedridden, and deaths would follow from pneumonia and exacerbated cardiac conditions as fluids accumulate; that stroke patients would suffer further loss of functioning; chronic brain syndrome patients would "just quit;" and that medical conditions would decline in general.

All transfer trauma witnesses, including the county's expert, agreed that there is a powerful connection between the termination of associations among patients and

between patients and staff and mortality risks accompanying a transfer. All acknowledged that the only successful transfers of comparable populations were accomplished by moving the staff with the patients. See Appendix 2. All agreed that the same debilitation which places patients at risk for purposes of transfer trauma also makes them heavily dependent upon interpersonal relationships. All accepted the formulation of Professor Lieberman that transfer trauma is largely the product of violating associational interests:

> [T]he predominant risk is related to destruction of interpersonal relationships between the patient and other human beings, patients and staff, which relationships comprise the social fabric of which the patient is a part.

Finally, all witnesses who addressed the issue, including the county's expert and the residents' doctor, agreed that a

move would be contrary to standards of due care and violative of the residents' best interests.

The residents' appeal from the trial court's judgment of dismissal, and the denial of their motion for summary judgment, is presently pending before the Ninth Circuit Court of Appeals. The plaintiffs continue to reside at Edgefield Manor, and await an argument date although the case has been fully briefed for over a year.

SUMMARY OF ARGUMENT

Although amici support the Third Circuit's position that provisions assuring a free choice of title XIX providers, limiting nursing home transfers, and establishing hearing rights evidence a sufficient "expectancy" to require the application of due process, amici submit that the implications of transfer trauma

and the statutory requirement that Medicaid services be provided in a manner consistent with the best interests of recipients greatly strengthen the conclusion that hearing rights exist and bear heavily upon what process is due.

Transfer trauma in fact kills many nursing home residents who are moved against their will, whether or not the move is occasioned by a decertification, and whether or not the move is intended to serve the residents' welfare. Regardless of whether statutes and regulations create an expectancy sufficient to trigger the "property" facet of due process, transfer trauma requires the application of due process because due process protects "life, liberty and property."

Because transfer trauma occurs primarily as a result of the destruction of interpersonal relationships between residents and relatives, friends, and staff

members, and among residents, and because such associational interests fall within the ambit of the "liberty" facet of due process, involuntary transfers would require due process rights even if life and property were not at stake.

Title XIX statutes require "such safeguards as may be necessary to assure that . . . care and services . . . will be provided in a manner consistent with simplicity of administration and the best interests of the recipients." 42 U.S.C. § 1396a(a)(19). Apart from the regulatory bases of an expectancy in continued residency at any particular institution, the best interests statute creates an expectancy that benefits will be delivered in a manner consistent with the resident's best interests. Because transfer trauma poses a real and substantial threat to the lives and well being of title XIX recipients, the "property" right to benefits consistent

with a recipient's best interests is at stake in every involuntary transfer dispute.

The statutory best interest guarantee also provides a complete answer to the suggestion that the regulatory transfer restrictions apply only against the provider and that residents' interests in decertification are "vicarious," as the best interest requirement clearly runs in favor of residents and against HEW and the state agency responsible for administration of the title XIX plan.

Moreover, the best interest statute forecloses any rejection of the regulatory hearing right argument on the theory that a transfer involves no "reduction" in benefits for purposes of 45 C.F.R. § 205.10. Given the allegation that an involuntary transfer may be deadly or at least severely violative of the right to receive benefits consistent with a recipient's best interests, an involuntary

transfer -- even to a purportedly higher level of care -- can easily constitute a reduction in benefits consistent with the recipient's best interests.

Independently of 45 C.F.R. § 205.10, rights to a hearing are in fact essential as "safeguards which [are] necessary to assure that . . . care and services will be provided in a manner consistent with . . . the best interests of the recipients." 42 U.S.C. § 1396a(a)(19). Transfer trauma must be weighed against factors favoring decertification or transfer to determine whether decertification is in fact consistent with a recipient's best interests. Even if an individual or decertification transfer is unavoidable, the best interest requirement dictates that transfer trauma be minimized by reducing interference with associational interests as much as possible and by other means typically peculiar to each individual resident, his or her medical

and cognitive condition, and his or her interpersonal relationships. Amici submit that because hearing rights are essential to assuring that transfer trauma receives adequate attention in both determinations -- whether and how to move -- the best interest requirement demands hearing rights by its own force.

Transfer trauma and best interest considerations also bear heavily upon what process is due. Because life itself is at stake, a resident opposing a transfer decision must have the opportunity to address the ultimate issue of whether the cause for an individual or decertification transfer exists and, if so, whether the harm threatened by the transfer is worse than that threatened by the basis of the transfer -- and whether means less onerous than a transfer exist to remedy the situation. In short, a resident must have a meaningful opportunity

to address all aspects of whether the transfer is in fact consistent with his or her best interests.

This determination potentially involves medical and expert evidence. But, unlike the Mathews v. Eldridge context, where the relevant agency and its experts are both neutral and fully equipped to determine the existence vel non of a disability, the context of an involuntary transfer offers neither of these justifications for deference to a medical bureaucracy. In an individual transfer context, medical evidence cannot be fairly presumed to be neutral, and it is frequently ignorant of regulatory criteria critical to the legality of a transfer; both are dramatically illustrated by the facts of Mrs. Harris' case.

In a decertification context, state and federal bureaucracies have a very real incentive to minimize or to ignore the

implications of transfer trauma because of the administrative burdens which full recognition of the phenomenon represents. Moreover, the personnel responsible for a decertification decision have no direct access to the associational realities of a resident's life or to a meaningful analysis of the risk of trauma particular to a given resident or resident population in light of medical and cognitive condition, interpersonal relations, and other factors affecting risk.

Life is at stake in all involuntary transfer decisions. Although full hearing rights will presumably be invoked only rarely, the nature of the essential evidence and the severity of the consequences of error demand that the right to a full evidentiary hearing, with full opportunity to present medical and other expert testimony, be afforded prior to every involuntary transfer. In a contested decertification

context, a joint hearing would be appropriate, but only full opportunity to present evidence as to the consequences of decertification for each resident can equip a decisionmaker to determine whether decertification is really preferable to the alternative possibilities.

Those possibilities, in a decertification context, are typically these: tolerate continued violation of applicable regulations, or accept the challenge of developing and employing tools such as fines, regulatory orders, implied civil remedies in the nature of injunction, and even receivership, to accomplish compliance without the cost of transfer trauma. It is submitted that only the latter is consistent with the statutory best interest requirement.

I

TITLE XIX REGULATIONS CREATE A "LEGITIMATE EXPECTANCY"

Amici respectfully concur in the Third Circuit's analysis that regulations assuring a free choice of provider, a grievance hearing, and protection against unwarranted transfers evidence a sufficient expectancy to create a due process property interest. Klein v. Califano, 586 F.2d 250, 257-59 (3d Cir. 1978).

Other cases similarly finding that title XIX nursing home residents have pretransfer hearing rights are: Bracco v. Lackner, 462 F. Supp. 436 (N.D. Cal. 1978); Kane v. Parry, 88 Misc.2d 1019, 371 N.Y.S.2d 605, reversed, 390 N.Y.S.2d 191, 55 App. Div. 678, reversed, 41 N.Y. 2d 1051, 396 N.Y.S.2d 182, 364 N.E.2d 846 (1977); Gardner v. Parry, 88 Misc.2d 154, 386 N.Y.S.2d 322 (S.Ct. 1976); Stitt v. Manor Care, Inc., CCH Medicare &

Medicaid Guide, ¶ 29, 409 (N.D. Ohio, Oct. 24, 1978); Roberson v. Wood, 464 F. Supp. 983 (E.D. Ill. 1979); Feld v. Berger, 424 F. Supp. 1356 (S.D.N.Y. 1976); Yaretsky v. Blum, 592 F.2d 65 (2d Cir. 1979). See also, Hathaway v. Mathews, 546 F.2d 227 (7th Cir. 1976); Memphis Light, Gas and Water Division v. Craft, 436 U.S. 1, 7-11 (1978); Geneva Towers Tenant Organization v. Federated Mortgage Investors, 504 F.2d 483, 489-91 (9th Cir. 1974); Caramico v. Secretary of the Dept. of HUD, 509 F.2d 694, 700 (2d Cir. 1974); Joy v. Daniels, 479 F.2d 1236, 1241-42 (4th Cir. 1973); Escalera v. New York City Housing Authority, 425 F.2d 853, 861 (2d Cir. 1970), cert. denied, 400 U.S. 853 (1970); Burr v. New Rochelle Municipal Housing Authority, 479 F.2d 1165, 1168-69 (2d Cir. 1973).

Amici have but three points to add to the Third Circuit's analysis. First,

assuming, as does the Third Circuit, that free choice of provider and transfer limiting regulations are not offended by transfers precipitated by a validly adopted decertification order, the expectancy which triggers the requirements of due process is that decertification will only occur when required by the welfare of the residents. See 42 C.F.R. § 449.12(a)(1)(ii)(B)(4). Whether residents' welfare is truly served by decertification transfers is in fact the issue posed by resident objections to decertification; in the words of Memphis Light,

> the Fourteenth Amendment's protection of "property" . . . has never been interpreted to safeguard only the rights of undisputed ownership.
>
> 436 U.S. at 11, quoting Fuentes v. Shevin, 407 U.S. 67, 86 (1972)

Second, the regulations are merely evidence of a greater expectancy. See,

e.g., Memphis Light, Gas & Water Division v. Craft, supra, 436 U.S. at 11. The reality is that nursing home residents are in fact dependent upon their institutional environment and whatever family and friends they may have as regular visitors for all the incidents of human relationships. In their day-to-day lives, the institution is their entire world.

> It is a purpose of the ancient institution of property to protect those claims upon which people rely in their daily lives, reliance that must be arbitrarily undermined.
>
> Board of Regents of State Colleges v. Roth, 408 U.S. 564, 577 (1972)

Third, the Town Court dissent is incorrect both in reading the transfer limitations as running only against the provider and in concluding from that reading that residents have no due process property interest in continued occupancy.

Title XIX is precisely parallel to categorical welfare programs in that it is a scheme of cooperative federalism under which federal monies are conditioned upon submission by participating states of a detailed "plan" which meets the satisfaction of the Secretary of HEW and fulfills regulatory prerequisites. Compare 42 U.S.C. §§ 1396 et seq. with 42 U.S.C. §§ 601 et seq. Thus the transfer limitations are among the many prerequisites for participation and HEW's approval of a state plan for medical assistance. See 42 C.F.R. §§ 449.10, 449.12. As such, they are directly enforceable by recipients, just as prerequisites to participation in Aid to Dependent Children programs are enforceable by recipients. Compare Stanton v. Bond, 504 F.2d 1246 (7th Cir. 1974), with Carleson v. Remillard, 406 U.S. 598 (1972); Townsend v. Swank, 404 U.S. 282 (1971); Rosado v. Wyman, 397 U.S. 397 (1970); King v. Smith,

392 U.S. 309 (1968); and Bryant v. Carleson, 444 F.2d 353 (9th Cir. 1971); see T. H. v. Jones, 425 F. Supp. 873, 876-77 (D. Utah 1975) (three judge court); Mendoza v. Lavine, 412 F. Supp. 1105, 1106 (S.D.N.Y. 1976).

Courts have routinely rejected contentions that HEW's power to withhold funds (42 U.S.C. § 1396c) is the sole remedy for noncompliance, and have routinely recognized that title XIX, the plans, and HEW regulations create obligations directly enforceable by title XIX recipients. Califano v. Westcott, 47 U.S.L.W. 4817, 4821 (June 25, 1969); Stanton v. Bond, supra, Yanez v. Jones, 361 F. Supp. 701, 705 (D. Utah 1973); T. H. v. Jones, supra; see Aitchison v. Berger, 404 F. Supp. 1137 (S.D.N.Y. 1975); cf. Bryant v. Carleson, 444 F.2d 353. That HEW has tacitly or expressly approved of the alleged violation does not bar relief. Schaak v. Schmidt, 344 F. Supp. 99, 103 n.5

(E.D. Wis. 1971); T. H. v. Jones, 425 F. Supp. at 879-80; Smith v. Vowell, 379 F. Supp. 139, 161 (W.D. Tex. 1974), aff'd without opinion, 504 F.2d 759 (5th Cir. 1974); cf. Carleson v. Remillard, 406 U.S. at 602-03; Townsend v. Swank, 404 U.S. at 286 & n.3.

When title XIX recipients establish that a participating state is not meeting its title XIX obligations or providing mandated services, they are entitled to an order compelling the state to fulfill its obligations and to provide services. Stanton v. Bond, supra; Smith v. Vowell, supra. Likewise, title XIX recipients can enforce the title XIX requirement that even optional services, if included in the plan, "must be sufficient in amount, duration and scope to reasonably achieve their purpose." Dodson v. Parham, 427 F. Supp. 97 (N.D. Ga. 1977); 45 C.F.R. § 249.10(a)(5)(i); see also White v. Beal,

555 F.2d 1146 (3d Cir. 1977).

The fact that a right is created by federal statute does not deprive a party aggrieved by its violation of a remedy against the nongovernmental entity guilty of that violation. See, e.g., Cannon v. University of Chicago, ___ U.S. ___, 99 S.Ct. 1946 (1979).

Even were the Town Court dissent correct in deeming the transfer limitation regulation operative only aginst the provider, it does not follow that the regulation does not evidence a sufficient expectancy to trigger due process. That the governmental action threatening a property interest does not come from the same source as the property itself hardly renders the property beyond the protection of due process. See, e.g., North Georgia Finishing, Inc. v. Di-Chem, Inc., 419 U.S. 601 (1975); Sniadach v. Family Finance Corp., 397 U.S. 337 (1969).

II

TRANSFER TRAUMA MANDATES DUE PROCESS PROTECTION FOR LIFE AND LIBERTY

The trial court in Klein and at least two other courts have suggested that the harm caused by transfer trauma is itself a "reduction in benefits" sufficient to trigger regulatory hearing rights under 45 C.F.R. § 205.10(a). Klein v. Mathews, 430 F. Supp. 1005, 1010 (D.C.N.J. 1977), affirmed, Klein v. Califano, 586 F.2d 250 (3d Cir. 1978); Stitt v. Manor Care, Inc., CCH Medicare & Medicaid Guide, ¶ 29, 409, p. 9110 (N.D. Ohio, Oct. 24, 1978); Bracco v. Lackner, 462 F. Supp. 436, 453 (N.D. Cal. 1978). Accord, Gardner v. Parry, 88 Misc.2d 154, 386 N.Y.S.2d 322 (S.Ct. 1976). Amici concur, but contend that transfer trauma has constitutional significance as well.

Because transfer trauma involves a substantial risk of depriving many typical

nursing home residents of life itself, and because it reflects a grievous violation of associational interests, the "life" and "liberty" interests at stake in a decertification decision require the application of due process even if the title XIX provisions relied upon by the Third Circuit do not reflect a "property" interest, and even if transfer trauma does not inherently constitute a "reduction in benefits."

A. That Involuntary Transfers Are Life-Threatening Triggers the Protections of Due Process.

The Town Court dissent assumed blithely that "although transfer trauma is a legitimate concern for some residents, it is necessarily subordinate to the threat posed to all residents by substandard conditions." 586 F.2d at 296. Unfortunately, the tragic reality is that decertification transfers are fully

capable of inflicting far more damage -- both in extent and in numbers of residents affected -- than even serious violations of patient care standards. As evidenced by the studies collected in Appendix 2 and the testimony presented by the Residents of Edgefield Manor, a transfer may well kill one third, one half, or even a greater proportion of a nursing home population, and substantial medical decline among the survivors has been reported in every study which examined that effect of transfers. Death rates of eight or nine times normal have been observed.

Amici do not suggest that toleration of patient care violations is the necessary consequence of the implications of transfer trauma, or even that decertification is never justified.

They do suggest, however, that the phenomenon demands more creative and recipient-oriented approaches to enforcement

than those encouraged by the premise of the Town Court dissent. More to the point of the issues before this Court, that residents' lives are at stake entitles them to the protections of due process.

Amici acknowledge that "grievous loss" does not itself require the application of due process. Meachum v. Fano, 427 U.S. 215, 224 (1976). Amici submit, however, that the magnitude of the threat to the lives of nursing home residents is more than sufficient to demand the application of due process.

The Fifth and Fourteenth Amendments to the United States Constitution expressly protect the right to life, and this Court has deemed that right fundamental. Johnson v. Zerbst, 304 U.S. 458, 462 (1938).

Having recognized that the constitutional right of privacy affords a woman substantial protection in choosing whether to terminate a pregnancy, Roe v. Wade, 410

U.S. 113 (1973), proceeded to reject a state's argument "that the fetus is a 'person' within the language and meaning of the Fourteenth Amendment." 410 U.S. at 156-59:

> If this suggestion of personhood is established, the appellant's case [in support of abortion], of course, collapses, for the fetus' right to life would then be guaranteed specifically by the Amendment.
>
> Id. at 156-57, emphasis added

Roe v. Wade precludes any assertion that risking title XIX recipients' lives is constitutionally permissible because the risk is merely "statistical." Roe v. Wade concluded that the state could regulate abortions only after the first trimester of pregnancy because it is at that point that the statistical risk of mortality in abortion overtakes the mortality risk in childbirth. 410 U.S. at 162-64. Again, the court's conclusions that states can

forbid abortions which are not necessary to protect the mother's life or health after viability of the fetus (410 U.S. at 163-65) was fully cognizant of the statistical nature of the determination of viability. See 410 U.S. at 160 and authorities cited nn. 59 & 60. Finally, Roe v. Wade forbids any state to prevent an abortion which is necessary to protect the mother's life or health because of the mother's overriding right to life (see 410 U.S. at 163-65) even though the existence and extent of risk to the mother's life or health must be determined "in appropriate medical judgment" (410 U.S. at 164-65) -- precisely the sort of judgment which predicts dramatic mortality and morbidity increases as a result of nursing home transfers.

Amici submit that due process demands a hearing because life is at stake.

B. That Involuntary Transfers Violate Associational Interests Triggers Due Process.

As reflected in the transfer trauma literature and the undisputed evidence presented by the Residents of Edgefield Manor, it is primarily through destruction of interpersonal relationships that transfer trauma takes its toll. As recognized in the materials summarized in Appendix 2, nursing home residents have replaced the outside world with a substitute social fabric upon which they become dependent for all of their needs, a world consisting of familiar objects and interpersonal relationships; a world which is totally destroyed by the typical decertification transfer. It is the destruction of that world and the extreme "uncertainty, and the consequent psychological hurt" (Trop v. Dulles, 356 U.S. 86, 111 (1958)(Brennan,

J., concurring)) which renders transfer trauma fatal to infirm, elderly residents.

Amici submit that analysis of the associational interests at stake in a transfer decision reveals that the constitutional right to association is directly threatened by involuntary transfers; at the very least, a "liberty" interest is involved which is sufficient to require due process even if the "property" and "life" facets were inapplicable.

The First Amendment guarantees rights of association (e.g., Aptheker v. Secretary of State, 378 U.S. 500, 507 & n.7 (1964), and authorities cited).

Nursing home residents' associational rights rest squarely within two lines of cases protecting distinct nonpolitical associational interests. The first line recognizes the associational implications of helping relationships such as those between union members and their attorney,

among union members themselves, and between private and public social workers and those they serve. The second line ensures protection for family relationships, non-familial living arrangements, and purely social non-familial relationships.

NAACP v. Button, 371 U.S. 415 (1963), held that Virginia's attempts to prevent the NAACP from directing civil rights complainants to attorneys violated the First Amendment right of association. 371 U.S. at 428-29. Brotherhood of Railroad Trainmen v. Virginia, 377 U.S. 1 (1964), applied Button to require Virginia to allow a union to channel cases to attorneys it felt competent to represent its members.

This Court followed Button and Trainmen, and expressly denied that associational rights are limited to political circumstances, in United Mine Workers of America, District 12 v. Illinois State Bar Association, 389 U.S. 217 (1967). The opinion noted that the

association protected by Trainmen was "solely designed to compensate victims of industrial accidents. . . ." 389 U.S. at 223.

Thomas v. Collins, 323 U.S. 516 (1945), invoked First Amendment protections to void a court order requiring registration prior to soliciting members for a union.

The Tenth Circuit followed Thomas in holding a deputy sheriff's employment could not be conditioned upon non-membership in a labor union. Lontine v. VanCleave, 483 F.2d 966 (10th Cir. 1973). To the same effect are American Federation of State, County, and Municipal Employees v. Woodward, 406 F.2d 137 (8th Cir. 1969); McLaughlin v. Tilendis, 398 F. Supp. 315 (N.D. Ga. 1971) (three judge court); and Atkins v. City of Charlotte, 296 F. Supp. 1068 (W.D. N.C. 1969) (three judge court). See also Franceschina v. Morgan, 346 F. Supp. 833

(S.D. Ind. 1972).

It is submitted that the therapeutic nature of the relationships between staff members and nursing home residents, coupled with the fact that many residents are dependent upon their staff for virtually all of their needs, requires recognition that First Amendment associational interests are threatened by any course of action which will terminate such relationships. If the First Amendment is offended by union organizor registration requirements, First Amendment interests are at least affected by any decertification decision which terminates relationships between patients and staff -- especially since it is primarily termination of those relationships which makes a transfer deadly.

The other major line of First Amendment association decisions which supports Amici's position centers around relationships involving family and friends.

Whatever the ultimate rationale of Griswold v. Connecticut, 381 U.S. 479 (1965), the opinion squarely recognized that social forms of "association" are within the First Amendment's protection. 381 U.S. at 575. In extending Griswold's protection of rights to obtain contraceptives to unmarried couples, Eisenstadt v. Baird, 405 U.S. 438 (1972), noted that a couple is "an association of individuals." 405 U.S. at 453.

Although Griswold and Eisenstadt both involve many constitutional rights, other opinions have focused exclusively on the First Amendment to protect marital and quasi-familial relationships. E.g., Randle v. Indianola Municipal Separate School District, 373 F. Supp. 766 (N.D. Miss. 1974); Doherty v. Wilson, 356 F. Supp. 35 (M.D. Ga. 1973).

United States Department of Agriculture v. Moreno, 413 U.S. 528 (1973), affirmed a

decision of a three judge court (Moreno v. United States Department of Agriculture, 345 F. Supp. 310 (D. D.C. 1972)) voiding statutes and regulations denying food stamp eligibility to households of unrelated persons. Although it ultimately relied on equal protection, the district court had invoked freedom of association to reject the Government's assertion of a legitimate interest in regulating morality. 345 F. Supp. at 314. In affirming, this Court cited the district court's freedom of association analysis with apparent approval. 413 U.S. at 535, n.7.

More recently, Smith v. Organization of Foster Families for Equality & Reform, 431 U.S. 816 (1977), considered a claim that New York afforded insufficient due process rights when removing a child from a foster home. Reviewing the cases protecting biological families, the court noted:

> [B]iological relationships are not exclusive determination of the existence of a family. . . .
>
> * * * *
>
> [T]he importance of the familial relationship, to the individuals involved and to society, stems from the emotional attachments that derive from the intimacy of daily association . . . .
>
> 431 U.S. at 843-44, footnote omitted

Smith declined to decide whether foster parents' relationships warranted constitutional recognition notwithstanding the consensually temporary nature of the relationship from its inception and the potentially competing associational interests of natural parents; the Court held New York's procedure adequate in light of those factors assuming arguendo that the foster relationship constituted a "liberty interest." 431 U.S. at 847-56. In contrast, residents' relationships with staff are neither consensually temporary nor in competition with other relationships.

See, e.g., Klein v. Mathews, 430 F. Supp. 1005, 1007-10 (D. N.J. 1977), affirmed, Klein v. Califano, 586 F.2d 250 (3d Cir. 1978).

Although Smith and its authorities focused on nuclear families and child-rearing, there is no room for a suggestion that constitutional protections for "emotional attachments . . . deriv[ing] from the intimacy of daily association" are limited to quasi-parental relationships. Moore v. City of East Cleveland, 431 U.S. 494 (1977), voided an ordinance which limited occupancy of dwellings to nuclear families. In reversing the conviction of a woman whose crime was living with two first cousins who were her grandchildren, a plurality of this Court reasoned:

> Ours is by no means a tradition limited to respect for the bonds uniting the members of the nuclear family. The tradition of uncles, aunts, cousins, and especially

> grandparents sharing a household along with parents and children has roots equally venerable and equally deserving of constitutional recognition. Over the years millions of our citizens have grown up in just such an environment, and most, surely, have profited from it. Even if conditions of modern society have brought about a decline in extended family households, they have not erased the accumulated wisdom of civilization, gained over the centuries and honored throughout our history, that supports a larger conception of the family.
>
> 431 U.S. at 504-05, footnote omitted; opinion of Powell, Brennan, Marshall, and Blackmun, JJ.

Traditionally, the extended family was the device by which elders and the disabled received loving care and dignity in their final years. Although modern society has relegated nursing home residents to an institutional substitute for the extended family, many have been fortunate enough to form "emotional attachments . . . from the intimacy of daily association" which

are the equivalent of familial attachments. The "importance of these relationships to the individuals involved and to society" render them "equally venerable and equally deserving of constitutional recognition."

It should not be necessary, however, "to understand every nuance of the human relationships involved" (Mabra v. Schmidt, 356 F. Supp. 620, 635 (W.D. Wis. 1973)), for First Amendment associational protections extend to purely social relationships of far less importance to the persons involved. See, e.g., Gay Students Organization of University of New Hampshire v. Bonner, 507 F.2d 652 (1st Cir. 1974); Wood v. Davison, 351 F. Supp. 543 (N.D. Ga. 1972); Bruns v. Pomerleau, 319 F. Supp. 58 (D. Md. 1970).

This Court has expressly recognized that the right of association embraces even purely social relationships in Gilmore v. City of Montgomery, Alabama, 417 U.S. 556,

575 (1974).

> The associational rights which our system honors permit all white, all black, all brown, and all yellow clubs to be formed. They also permit all Catholic, all Jewish, or all agnostic clubs to be established. Government may not tell a man or a woman who his or her associates must be. The individual can be as selective as he desires.
>
> 417 U.S. at 575, quoting dissent of Douglas, J., in Moose Lodge No. 107 v. Irvis, 407 U.S. 163, 179-80 (1972)

Even if the associational interests at stake in an involuntary transfer decision do not fall within the constitutional right of association, they are necessarily embraced within the "liberty" facet of due process.

Concurring in Roe v. Wade, 410 U.S. 113 (1973), Justice Stewart argued that this Court had ressurected the concept of substantive due process. 410 U.S. at 167-70. To define that concept, Justice Stewart quoted a dissent of Justice Harlan describing

the "liberty guaranteed by the Due Process Clause" of the Fourteenth Amendment as

> not a series of isolated points pricked out in terms of the taking of property; the freedom of speech, press, and religion; the right to keep and bear arms; the freedom from unreasonable search and seizures; and so on. It is a rational continuum which, broadly speaking, includes a freedom from all substantial arbitrary impositions and purposeless restraints . . . and which also recognizes, what a reasonable and sensitive judgment must, that certain interests require particularly careful scrutiny of the state needs asserted to justify their abridgment.
>
> 410 U.S. at 168-69, quoting Poe v. Ullman, 367 U.S. 497, 543, dissent of Harlan, J.

Justice Stewart's contention was vindicated in Moore v. City of Cleveland, Ohio, supra, which struck an ordinance prohibiting members of an extended family from living in the same single dwelling. Four justices (other than Justice Stewart) adopted Justice Harlan's definition of

substantive due process quoted above to void the ordinance. 431 U.S. at 502. At least five justices of this Court, then, share Justice Harlan's definition of substantive due process.

In Roe v. Wade, Justice Stewart also quoted the words of Justice Frankfurter:

> Great concepts like . . . "liberty" . . . were purposely left to gather meaning from experience. For they relate to the whole domain of social and economic fact, and the statesman who founded this Nation knew too well that only a stagnant society remains unchanged.
>
> 410 U.S. at 169, citing National Mutual Ins. Co. v. Tidewater Transfer Co., 337 U.S. 582, 646, dissent of Frankfurter, J.

That "liberty" within the protection of the due process clauses emcompasses the sorts of associational interests at stake in a decertification transfer appears from the rationale of Morrissey v. Brewer, 408 U.S. 471 (1972). Morrissey held procedural

due process applicable to a parole revocation, but first explored the nature of the interests at stake to determine whether due process applied:

> Subject to the conditions of his parole, [a parolee] can be employed and is free to be with family and friends and to form the other enduring attachments of normal life. Though the State properly subjects him to many restrictions not applicable to other citizens, his condition is very different from that of confinement in a prison. He may have been on parole for a number of years and may be living a relatively normal life at the time he is faced with revocation. . . .
>
> We see, therefore, that the liberty of a parolee, although indeterminate, includes many of the core values of unqualified liberty and its termination inflicts a "grievous loss" on the parolee and often on others. It is hardly useful any longer to try to deal with this problem in terms of whether the parolee's liberty is a "right" or a "privilege" by whatever name, the liberty is valuable and must be seen as within the protection of the Fourteenth Amendment. . . .
>
> 408 U.S. at 482, emphasis added

Amici submit that their interpersonal relationships which form a social fabric, and upon which their well being and even their lives may depend, are within the "core values" of the liberty protected by the due process clauses. Amici further submit that because an involuntary transfer threatens these liberty interests, due process must apply wholly apart from "property" and "life" analyses.

III

STATUTORY BEST INTEREST REQUIREMENTS DEMAND A HEARING

Prerequisite to a state's participation in title XIX is submission of a "State plan for medical assistance" which "must" inter alia,

> provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided in a manner consistent

> with simplicity of administration and the best interests of the recipients.
>
> 42 U.S.C. § 1396a(a)(19)

Amici submit that this statute requires hearings -- as a matter of due process or regulatory or statutory construction -- for four reasons.

First, the best interest requirement strengthens the evidence of a legitimate entitlement sufficient to constitute a "property" interest. It reflects that the transfer, hearing, and free choice of provider provisions relied upon by the Third Circuit are not mere incidents of scheme primarily designed for some other purpose -- such as the economic well being of the health industry -- but are corollaries of a public assistance program whose primary beneficiaries are the recipients themselves. This distinction provides a complete answer to the suggestion of the

Secretary of HEW (Br. at 29-31) that residents' interest in decertification are akin to those of an employee of a government contractor. A title XIX recipient's interests in whether the only home he or she may know will cease to exist is hardly "vicarious" with respect to the statutory scheme ensuring recipients' best interests. Moreover, the public assistance thrust of the statute forecloses any denial of a "property" interest on the basis of a "privilege" vs. "right" argument. Goldberg v. Kelly, 397 U.S. 254, 261-62 (1970).

Second, the best interest requirement answers any argument that the regulatory incidents invoked by the Third Circuit run only against the provider. The best interest requirement is a statutory criterion which a participating state must meet and with which the Secretary of HEW, in passing

on the statutory adequacy of a state plan, must assure compliance. See, e.g., 42 U.S.C. §§ 1396a, 1396c. As noted previously, this structure is precisely parallel to that of categorical public assistance programs in which this Court has found such criteria actionable directly by recipients. See authorities cited pp. 31-34, supra.

Third, the best interest requirement answers the contention that a decertification (or a horizontal or upward transfer) entails no "reduction in benefits" for purposes of the regulation assuring hearings (45 C.F.R. § 205.10)[1] and no diminution

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1. The regulation's provision that "timely notice" may be dispensed with when the recipient "has been placed" in a nursing home (45 C.F.R. § 205.10(a)(4)(ii)(D)) affects only grant adjustments resulting from the resident's placement in the facility; it does not deprive residents of "timely" notice of a proposal to transfer them out of a facility or otherwise to affect assistance benefits. Feld v. Berger, 424 F. Supp. 1356, 1361-63 (S.D.N.Y. 1976).

of an "entitlement" for purposes of due process. Because subjecting residents to transfer trauma may very well reduce drastically -- and often fatally -- the extent to which services are provided "in a manner consistent with . . . the best interests of the recipients," a decertification determination may well defeat an expectancy just as completely as a termination of assistance altogether. It should not be necessary to add that death by transfer trauma certainly terminates the receipt of public assistance benefits.

Fourth, the statutory requirement is that the state plan "provide such safeguards as may be necessary to assure that . . . care and services will be provided in a manner consistent with . . . the best interests of the recipients." Amici submit that an opportunity to present evidence, to hear and to contest the views of HEW,

the state agency, and the provider -- in short, a hearing of some kind -- prior to a decertification is precisely such a "safeguard." That such a safeguard is "necessary" should follow from the consequences of error and a history which includes transfers which have done more harm through trauma than they accomplished through enhancing the "credibility" of enforcement. That such a safeguard is necessary is poignantly established by the posture of the Secretary of HEW and the Secretary of Public Welfare in this case.

The agencies responsible for ensuring residents' best interests -- and enforcing compliance with such regulations as those prohibiting transfers which are contrary to the welfare of recipients -- are actually taking the position that transfer trauma, which threatens the very lives of recipients, does not entitle recipients to any participatio

in decertification decisions; that residents have nothing to add to such decisions -- even though surveyors are frequently ignorant of the nature of residents' interpersonal relationships and the consequences of disrupting them; that decertification "means only that the patient will be required to move" (HEW Br. 41 n.47); and that permitting these agencies to persist in these views is essential to maintenance of their enforcement credibility with providers. Petitioners take these positions apparently without having made any attempt to assess how many residents are at high risk for purposes of transfer trauma -- i.e., without even knowing how many residents may suffer death or morbidity as a result of a decertification.

Amici respectfully submit that such views were accurately characterized as "rank paternalism" by the trial court in

Klein. 430 F. Supp. at 1011. Amici further suggest that such views compel the conclusion that an opportunity to dispute the basis for a decertification decision, before transfers, is a necessary safeguard required by the statute.

Amici are at least as concerned with the adequacy of enforcement mechanisms as are the petitioners. From the prespective of amici and their advocates, enforcement credibility suffers not because HEW and state agencies are reluctant to destroy the entire world perceived by many nursing home residents to vindicate the agencies' authority in the eyes of a provider. The agencies' enforcement credibility suffers precisely because they have proven insensitive to the world of recipients by remaining largely ignorant of many of its incidents and unresponsive to complaints concerning its infringement. By focusing on conveniently quantifiable indicia of care such

as chart contents, staff-patient ratios, and the like to the exclusion of the interests embodied in the "patients' bill of rights" (42 C.F.R. § 449.12(a)(1)(ii)(B)), agencies have abdicated half of their responsibility for the well being of recipients. In fact, the incidents of dignity and humanity guaranteed by the bill of rights are as important to the physical and psychological well being of recipients as are other patient care requirements. By taking the position that these rights can be ignored at its discretion, HEW does far more to undermine its enforcement credibility than by hesitating to subject residents to a life threatening transfer.

The credibility of such agencies would be greatly enhanced by overcoming the self-imposed dilemma posed by life-threatening patient-care violations and the alternative of life-threatening transfers.

A creative bureaucracy can devise enforcement mechanisms such as fines, administrative orders, and the like; if necessary, it can seek the entire range of judicial remedies through the implied remedy doctrine. See, e.g., Wyandotte Transportation Co. v. United States, 389 U.S. 191 (1967). Creative use of these mechanisms and remedies holds far more potential for enhancing enforcement credibility than the position of the agencies now before this Court.

IV

TRANSFER TRAUMA AND BEST INTEREST CONSIDERATIONS REQUIRE A PRIOR EVIDENTIARY HEARING

There is little room for dispute as to what criteria govern the requisites of due process. Generally, what process is due is determined by the nature of the private interest at stake, the risk of error and value of additional procedural safeguards, and the governmental interest.

Mathews v. Eldridge, 424 U.S. 319, 334-35 (1976); Memphis Light, Gas and Water Division v. Craft, 436 U.S. 1, 17-18 (1978); Parham v. J.L. and J.R., ___ U.S. ___, ___, 47 U.S.L.W. 4740, 4744 (June 20, 1979). Whether the "hearing" is "documentary" or "evidentiary" depends upon the nature of the issues which are determinative at the hearing. Compare Mathews v. Eldridge, supra, 424 U.S. at 344-45, with Califano v. Yamasaki, ___ U.S. ___, ___, 47 U.S.L.W. 4765, 4768-69 (June 20, 1979), and Goldberg v. Kelly, 397 U.S. 254, 269 (1970). Whether the hearing must occur prior to the initial deprivation depends upon the impact and practical finality of that deprivation. Compare Mathews v. Eldridge, supra, 424 U.S. at 340-49 with Memphis Light, supra, 436 U.S. at 19-20.

The petitioners and the Town Court dissent variously resist the requisites of due process in this context by derogating

the interests of recipients, the risks of error, and the benefits of additional safeguards, and by exaggerating the burden imposed by the Third Circuit's decision. HEW suggests that the issues of whether a hearing must occur prior to decertification and what process is due be determined on remand. HEW Br. at 42 n.47.

Amici contend that the resistance to the requisites of due process is based upon critically erroneous factual assumptions concerning all criteria, that an opportunity for a prior hearing is unavoidably required, and that although this Court has ample basis for insisting upon a Goldberg prior evidentiary hearing opportunity, it may not entertain the factual assumptions necessary to a contrary result without a remand. Because of the potential impact of this Court's resolution of these issues upon individual transfer situations, amici will note in passing the variations

of analysis relevant to individual transfers.

A. The Individuals' Interests Are Compelling.

HEW minimizes the residents' interest in a transfer by contending that it is the provider which has "the greatest interest" in avoiding decertification, and that decertification does not affect a right to title XIX benefits but "means only that the patient will be required to move from one place to another." HEW Br. 40-41 & n.47. The Town Court dissent at least is free of HEW's apparent reluctance to utter the words "transfer trauma," but dismisses the concept as "necessarily subordinate to the threat posed to all residents by substandard conditions." 586 F.2d at 296. In short, the contention is that the interest of residents in resisting a move is minimal, mixed, or both. Amici disagree.

Again, transfer trauma poses not just an occasional risk to peculiarly sensitive individuals, but a risk of dramatic rises in mortality and morbidity affecting all elderly and infirm nursing home residents. Moreover, although the risk varies with the cognitive and physical condition of each resident, it is correlated with precisely those conditions which typically afflict nursing home residents, and precisely those conditions which render residents especially vulnerable to other life-threatening circumstances -- such as patient-care violations. In other words, the risk of death or dramatic medical decline from transfer trauma often exceeds that of death or decline from patient-care violations, and the risk is highest with respect to the residents most vulnerable to patient-care violations. It is not a question of ignoring the few for the many -- it is the same people who will be injured

or killed by a move who are most threatened by patient-care violations which typically precipitate a decertification issue. See Part II and Appendix 2.

In the individual transfer context, such as that presented by amicus Jill Harris, a resident resisting transfer -- given the opportunity -- typically disputes the provider's contention that medical considerations favor a transfer, either by contesting the argument that a move is indicated or by attempting to show that a transfer is more inimical to the resident's welfare than the risk of remaining in the facility. Although such a context precludes a "mixed interest" argument like that of the Town Court dissent, the error of the argument is similar in the decertification context. Although some may suffer more than others from whatever violations precipitated the issue of decertification, all have a great interest in curing the violations without

the cost of a move, and the ultimate question is whether unavoidable risks of remaining are so life threatening as to make a transfer acceptable even given its risks. That the dilemma is severe cannot reduce the private interest to insignificance for purposes of due process.

Even aside from transfer trauma, it is not "only" a "move from one place to another" which is at stake to residents. Whether a resident's subjective reality is limited to the sights and sounds of a single room or extends to the full expanse of the social fabric within a facility which replaces the outside world, it is the resident's entire world which is at stake. For residents fortunate enough to preserve regular contact with outside friends and family, these associations are typically threatened by a decertification transfer as well. See pp. 4-9, supra.

Accordingly, the interests of residents are neither minimal nor mixed. All are interested to the extent that lives and medical condition hang in the balance, and the world-shattering impact of decertification is at best a lesser evil which is still of enormous magnitude. All have an interest in avoiding both patient-care violations and a life-threatening transfer. If any residents would just as soon move, or require a move in an emergency situation, nothing prevents their move to another facility without a hearing except the possibility that no such facility exists -- a possibility at odds with the petitioners' assumptions.

B. The Risks of Error and Need for Additional Safeguards Are Demonstrated by Petitioners' Arguments.

Both HEW (HEW Br. at 41 n.47) and the Town Court dissent (586 F.2d at 296-97)

argue that the provider's interest in avoiding decertification and the role of surveying teams minimize both the risk of error and the value of residents' participation. These arguments are based upon a myopic exclusion of best interest and transfer trauma considerations and ignore fundamental distinctions between the interests of residents and those of providers.

Were HEW and state agencies fully responsive to their best interest obligations and cognizant of the risks of transfer trauma, this Court might well engage in the sort of analysis which characterized Mathews v. Eldridge, supra, and Parham v. J.L. and J.R., supra. In those cases, this Court found that the critical and narrow medical issue was directly addressed by fully informed and competent personnel so that the risk of error and value of additional safeguards were minimal. If HEW, state agencies and

surveyors routinely scrutinized not only patient-care violations but alternate means of enforcing provider compliance, and if they regularly and reasonably collected patient medical and associational information and calculated the extent of risk to residents posed by a transfer, perhaps they would be able to address the ultimate issue of whether decertification is consistent with best interest requirements or required to protect residents' welfare.

But HEW is urgently trying to ignore transfer trauma, and has gone to the extreme of contending more is at stake for the provider than for residents -- who may die from a transfer -- in a decertification context. Although surveyors seem well equipped to scrutinize charts for missing records, to note objective conditions of cleanliness and staffing, and to record patient complaints, there is no apparent bureaucratic regimen for collecting

information critical to assessing the risks of transfer.

For example, even if the surveyors have access to information concerning patients' medical and cognitive diagnoses, there is no process built into the decertification procedure for correlating those diagnoses with risk of death or medical decline in a transfer -- as was done for the Residents of Edgefield Manor. Nor is there any assurance that surveyors or anyone else connected with the process will ascertain the critically important social incidents of residents' dependencies -- such as how many residents will lose potentially life-sustaining family visits, or even whether alternate facilities exist and whether resident affinity groupings can be preserved in the transfers necessitated by a decertification.

It cannot be assumed that doctors or other medical personnel involved in a survey

team are familiar with transfer trauma or with the patient conditions which correlate with high risk in a move. The doctor who supported the facility's request for a transfer in Jill Harris' case conceded he was unfamiliar with transfer trauma. Most experts in the field are not medical doctors but behavioral scientists. See authorities cited Appendix 2.

Amici submit that agencies and surveyors operate under routines which effectively preclude the receipt and consideration of evidence critical to at least half of the decisionmaking process, and that the risk of error and potential for improvement from resident involvement is accordingly overwhelming. The issue, again, is not merely whether violations exist, but whether decertification is required by residents' welfare and consistent with their best interests. Apparently, the petitioners have made no

attempt whatever to compare the risks of harm to residents from the patient-care violations at Town Court Nursing facility (HEW Br. 7 n.18) with risks posed by a decertification transfer. The very suggestion that the provider has more at stake than residents establishes that they have not done so.

Residents may have little to add to consideration of issues of fire safety, staff credentials, or nutrition. HEW Br. 41 n.47. But the issues they can address -- such as which persons are a part of their lives, what incidents of their reality are important to them, and how urgently they want to stay -- may be even more critical to their well being.

Equally important, residents, or at least their advocates, may have quite a bit to say about what alternative enforcement devices might be available against the provider short of decertification.

The availability of such devices may well involve questions of law, but, if necessary, implied remedies should ultimately provide a full range of enforcement tools. Compare, e.g., Wyandotte Transportation Co. v. United States, 389 U.S. 191, 202-03 (1967), with Bell v. Hood, 327 U.S. 678, 684 (1946). And the sufficiency of such devices to cure existent violations is, of course, a question of fact.

It is critical to note that here the interest of the provider is quite different than that of the residents. Saving residents' lives by avoiding transfers may require enforcement devices which are financially unattractive to providers. Particularly where the provider has private pay as well as title XIX patients, decertification may pose little or no threat. Indeed, amici have personal and lamentable experience with providers who would just as soon lose "unprofitable" welfare patients.

See, e.g., Appendix 1. At the very least, a provider might well argue for waiver of compliance or minimal improvement when a resident's advocate might demand strict enforcement in lieu of decertification.

Of course, no assumption of provider representation can apply to an individual transfer situation, where resident and provider interests may be directly at odds. Again, however, the individual context illustrates that this Court cannot safely assume that the provider's participation in the decertification process adequately protects the interests of residents.

C. Burden Cannot Justify Foregoing Critical Inquiries.

HEW's suggestion that prior evidentiary hearings will impose a tremendous burden of a separate hearing for each resident and for the provider (HEW Br. at 42 n.47) erroneously assumes that a decertification

hearing cannot be held jointly, and, given the financial resources of title XIX recipients, joint representation is likely to be the rule. More important, the "burden" of HEW and state enforcement agencies is largely self-imposed and therefore of little weight.

First, exploring enforcement devices other than decertification should avoid most decertification disputes altogether, and with them the need for resident participation at decertification hearings.

Second, routinizing the collection and consideration of evidence relevant to assessing the risks of transfer trauma to a facility's population (and the devices for minimizing harm if a move proves necessary) would reduce both the necessity for an "evidentiary" form of hearing and the argument that residents have a right to go beyond the submission of documentation. Compare Goldberg v. Kelly, supra, 397 U.S.

at 266-71, with Mathews v. Eldridge, supra, 424 U.S. at 345-47.

Third, the statutory demand is that HEW accommodate both "simplicity of administration and the best interests of the recipients." 42 U.S.C. § 1396a(a)(19). At least until HEW and state agencies adequately collect and consider the evidence they now routinely ignore, both simplicity and best interests cannot be honored without a full opportunity for residents and their advocates to present that evidence and insist upon its consideration.

The individual transfer hearing may similarly be subject to simplification if HEW and state agencies recognize that the resident is entitled to dispute the provider's assertion (or that of a commonly "captive" doctor -- see Appendix 3) that the resident's welfare requires a transfer. But until the resident is afforded some other form of opportunity to address the

ultimate issue of medical best interests before a neutral decisionmaker (e.g. Mathews v. Eldridge, supra; Parham v. J.L. and J.R., supra), a plenary evidentiary hearing is necessary. Moreover, because credibility and the weight of conflicting medical opinions will be typically critical, an oral hearing is required. Cf. Califano v. Yamasaki, supra.

D. A Prior Hearing and Adequate Notice Are Required.

Amici submit that once it is recognized that residents' lives are at stake in a decertification decision, and that even the survivors of a transfer are likely to experience irreversible medical decline, the right to a prior hearing follows inevitably. Goldberg v. Kelly, supra, 397 U.S. at 260-61; Memphis Light, Gas and Water Division v. Craft, supra, 436 U.S. at 19-20.

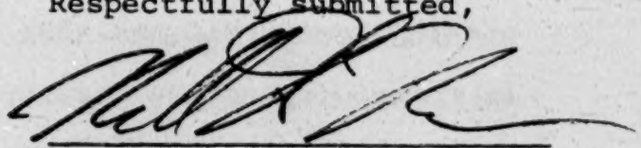
Amici further submit that the correct response to the Town Court dissent's concern for the senility and incompetence of many nursing home residents (586 F.2d at 297) is to require notice "tailored to the capacities and circumstances of those who are to be heard." Goldberg v. Kelly, supra, 397 U.S. at 268-69; Memphis Light, Gas and Water Division v. Craft, supra, 436 U.S. at 14-15 & n.15. In the case of incompetent residents -- who are typically not subject to any adjudication of incompetence -- the agencies should be required to make reasonable efforts to give notice to any friends or relatives known to the facility or to caseworkers. Cf. Mullane v. Central Hanover Trust Co., 339 U.S. 306, 314 (1950).

CONCLUSION

Amici respectfully submit that the

judgment of the court of appeals should be affirmed.

Respectfully submitted,



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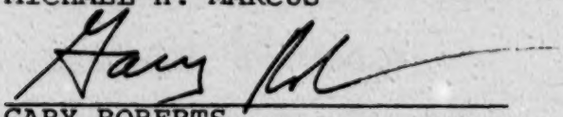

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JULY 1979

APPENDIX 1

Rose Haven
748 N. W. HILL PLACE
ROSEBURG, OREGON 97470
PHONE 672-1631

January 12, 1978

Mr. John Robinson, Manager
Adult and Family Services Division
Roseburg Branch
P.o. Box 70
Roseburg, OR 97470

Re: Glen Hufman Helen Martin
Ralph Clark Lillian Beaudry

Dear Mr. Robinson:

Due to the new reimbursement formula the Adult and Family Services Divsion has decided upon for support of welfare patients in Oregon nursing homes; Rose Haven is re-evaluating its welfare patients. Any welfare patient that requires an excessive amount of nursing staff time will be transferred out of the facility after the proper 14 day notification to the Adult and Family Servies Division has been given.

I have reluctantly taken this action because of the severe economic restaints the Division has placed on nursing homes in Oregon. Rose Haven cannot continue to sell its services for less than the cost of providing those services. Thus, we at Rose Haven must be very careful that the welfare patients we have do not require excessive staff time to care for them.

The four patients listed above have been evaluated and it has been determined that they are requiring an excessive amount of staff time and will have to be transferred.

On January 27, 1978 the four nursing beds now occupied by the above patients will be given to four private patients who are currently on our waiting list.

If you have any questions please feel free to call.

Sincerely,

ROSE HAVEN, INC.

Duane G. Miner
Administrator

DGM/dp

cc: Kay Knox

APPENDIX 2

SUMMARY OF RELOCATION LITERATURE

Amici submit that Roe v. Wade, 410 U.S. 113 (1973), provides ample precedent for direct recourse to medical literature concerning mortality risks. Roe in relevant part affirmed a district court judgment declaring a Texas criminal abortion statute unconstitutional. After finding a pregnant woman's right to privacy sufficient to bar state regulation of her right to procure abortion absent a compelling interest, the Court proceeded to find the state's interest in the woman's health sufficient to warrant state regulation of "the abortion procedure in ways that are reasonably related to maternal health" after the first trimester of pregnancy because "until the end of the first trimester mortality in abortion may be less than mortality in normal childbirth." 410

U.S. at 163-64. The Court drew support for its conclusion concerning the relative mortality risks from literature of the same kind as here invoked by Amici. Id. at 149 & n.44.

Professionals within various fields of social and medical science have generated a substantial body of literature exploring various aspects of "transfer trauma" -- a term denoting stress associated with relocation. Although, as in any field, the literature reveals that much is left to be learned about transfer trauma, several propositions flow from the literature without contradiction:

1. A transfer of a population of institutionalized elderly persons with substantial cognitive and/or physical impairment involves a grave risk of dramatic increases in death rates and illness if the staff does not move with the patients;

2. Although relatively healthy populations of elderly persons have been moved without apparent increase in death rates, all studies which have addressed the question have discovered evidence of increased morbidity occasioned by the transfer;

3. Great reductions in transfer mortality have been accomplished by retaining the same staff, but evidence of increased morbidity in such transfers remains.

Probably the first published study of an inter-institutional transfer of infirm elderly was Aldrich and Mendkoff, Relocation of the Aged and Disabled: A Mortality Study, 11 J. Am. Geriatrics Society 185 (1963). Aldrich and Mendkoff studied the transfer of 182 patients occasioned by the closing of the Chicago Home for Incurables in 1958-61. For each age decade within the population transferred, the authors compared death rates for the year following the transfer with an expected death rate calculated upon ten years' experience at the

institution prior to the relocation. They found the annual mortality rate for all ages had increased from 19 to 32%, and for all ages 70 and older, from 23 to 38%. More significantly, the authors found:

> Analysis of the deaths according to the months elapsed since relocation (Table 3) showed that the number of deaths in the first three months was substantially higher than during the remainder of the year. The actual and expected death rates in the last nine months of the year were approximately the same; in the first three months of the year the actual death rates for patients over 70 was about three and a half times as high as the expected death rates, and for all patients it was more than three times as high as the expected death rate. The significant increase in the death rate, therefore, occurred primarily in the first three months following relocation.
>
> pp. 187-88, footnote omitted

The authors discounted seasonal variation as explanation for the three month peak. P. 187 n.3.

The three month period is now typically regarded as critical for reflecting the impact of relocation. Bourestom and Tars, Alterations in Life Patterns Following Nursing Home Relocation, 14 Gerontologist 506, 508 (1974); Gutman and Herbert, Mortality Rates Among Relocated Extended-Care Patients, 31 J. of Gerontology 352, 356 (1976); Novick, Easing the Stress of Moving Day, 41 Hospitals, J.A.H.A. 64, 74 (1967); Kahn and Kaplan, Phase-Out of Grafton State Hospital, Interim Report 15 (Mass. Dept. Mental Health) (1974). Other investigators have used periods other than three months, but short of a year, to assess transfer trauma. Brody, Kleban and Moss, Measuring the Impact of Change, 14 Gerontologist 299 (1974) [two weeks, four months, eight months]; Jasnau, Individualized Versus Mass Transfer of Non-Psychotic Geriatric Patients from Nursing Homes, With Special Reference

to the Death Rate, 15 J. Am. Geriatrics Society 280, 282-83 (1967) [six months]; Killian, Effect of Geriatric Transfers on Mortality Rates, 15 Social Work 19, 20, 24 (1970) [four months]; Kral, Grad, and Berenson, Stress Reactions Resulting from the Relocation of an Aged Population, 13 Canad. Psychiat. Ass. J. 201, 204 (1968) [four months, six months]; Markus, Blenkner, Bloom, and Downs, Some Factors and Their Association with Post-Relocation Mortality Among Institutionalized Aged Persons, 27 J. of Gerontology 376, 377, 378 (1972) [nine months].

Aldrich and Mendkoff also found that death rates apparently rose in anticipation of the relocation, as well as after the relocation. For all ages, the expected mortality rate based on ten year calculations was 19%, but a rate of 30% was actually experienced during the period of anticipation; for ages 70 and older,

the rate apparently rose from 23% to 34%. The authors could not exclude the possibility that these figures were due to chance (i.e., the differences were not "statistically significant"), and hence concluded only that the figures "suggest[ ] a possible relationship . . ." 11 J. Am. Geriatric Society at 188, 192. Boureston and Tars, supra, in a study discussed below, reached findings they found "consistent with those reported by Aldrich and Mendkoff (1963) and [which] confirm their suggestion that anticipation of relocation has effects which are nearly as lethal as the relocation itself." 14 Gerontologist at 508. Although Killian, supra, did not expressly address the issue, he related the circumstances of two deaths which suggest they were a result of anticipation of relocation. 15 Social Work at 26.

Professor Morton A. Lieberman, Ph.D., of the University of Chicago, seems to have published far more articles on transfer trauma than anyone else in the field: Dr. Lieberman studied four distinct transfers. The relocation which involved a broad enough range of patients to enable Dr. Lieberman to explore the factors which correlate with a high risk of transfer trauma was deemed the "mass transfer." Lieberman, Relocation Research and Social Policy, 14 Gerontologist 494, 495-96, 500 (1974) Referring to the dramatic increase in death rates, Dr. Lieberman observed:

> Survival is clearly related to the physical and cognitive condition of the person; however, it is important to hasten to add that whatever evidence we have suggests that it is not simply that these individuals would have died had relocation not taken place -- for in contrast to a carefully matched control group in another state hospital, three times as many people died among the relocated.
>
> P. 500

Another often cited relocation study is that of Eldon Killian, Effect of Geriatric Transfers on Mortality Rates, supra, 15 Social Work 19 (1970). Killian studied the fate of two groups of residents of Stockton State Hospital who were relocated when a portion of that hospital was closed. The first group was transferred to other state hospitals, the second to nursing homes, convalescent hospitals, boarding homes, and family care homes. Both groups consisted exclusively of persons 60 years of age and older. Both groups were carefully matched with control groups with respect to age, sex, race, organic or functional diagnosis, length of hospitalization, and whether the patient was ambulatory. The groups studied and the control groups were alike in each of these respects, and differed only in that the control groups were not relocated. Killian found that the death rate of

the group transferred to other state hospitals was 4.98 times higher than the death rate of the control group, while the mortality rate for the group transferred to nursing homes and the like was 8.99 times that of the control group. 15 Social Work at 21, 25.

Kahn and Kaplan, in Phase-Out of Grafton State Hospital, supra, studied the impact of a transfer of the entire population of Grafton State Hospital in Massachusetts. Focusing on the fate of patients over 65 years of age, they found that 5% of these patients died within three months of the transfer, a figure equivalent to an annual mortality rate of 20% as compared with a five year average annual mortality rate of 7% among such patients prior to transfer. Drs. Kahn and Kaplan concluded:

> The mortality figures, within three months of transfer, could

> be considered as due to the stress of relocation itself, and this would be most significant to evaluating the success of the relocating procedure.
>
> Interim Report at 15

Although moving relatively healthy patients apparently does not create an imminent risk of increased mortality, every investigator who has examined the question has concluded that such a move does increase sickness among elderly persons. Professor Lieberman has insisted the inquiry must proceed beyond mere mortality rates:

> Foremost on my list of near idiocies has been the over-preoccupation with death rates. All too often investigators have been involved in what may appear to be a bizarre numbers game. If we manage to provide service to the very elderly by relocating them into institutional structures and find we have not statistically increased the probability of death, our subjective experience is a sense of relief, nay, almost a sense of victory and a feeling that

> we have done our job well. . . [T]o construct a rational policy of planning for the care of the elderly solely on the basis of minimizing the risk of mortality is narrow from a humanitarian perspective and also, I believe, scientifically suspect. . . .
>
> A more useful orientation for studying the effects of relocation would be to ask the question whether the individual departs, subsequent to being moved, in major ways from his prior physiological, behavioral, and psychological status. . . .
>
> 14 Gerontologist at 495

Professor Lieberman found dramatic physiological, behavioral, and psychological deterioration among substantial portions of all of the populations he studied. Of 45 "healthy and psychologically robust elderly . . . studied in a forced relocation from a small hotel-like institution to a larger quasi-military institution for the aged," "23 showed marked decline, including four deaths;" of 85 "community-dwelling aged . . . who voluntarily entered homes for the aged," "41 showed marked

decline, including 13 deaths;" of 82 persons constituting "a highly select group of geriatric mental hospital patients who were discharged to a variety of community based institutional and semi-institutional settings," "40 showed marked decline, including two deaths;" of 427 patients "who were relocated en masse from a state mental hospital to a variety of other institutions," "237 showed marked decline, including 78 deaths." 14 Gerontologist at 495-96.

Bourestom and Tars, supra, studied two relocations: a "radical change" group which moved from a county run medical facility to a private nursing home with an attendant change in staff and routine, and a "moderate change" group which moved to a modern building, but retained its staff and programs. 14 Gerontologist at 507. Focusing on morbidity, the authors found:

> Following the move, patients in the radical change group also showed a marked decline in the number of psychosocial activities engaged in such as occupational therapy and recreational therapy, whereas patients in the moderate change group showed little or no change in participation in these activities. Paralleling this decline in psychosocial activity was a corresponding increase in observed low level behavior in the radical-change group as reflected in the observation weighted score.
>
> Id. at 508

The authors were unable to report the figures beyond the first month after relocation because "mortality caused the sample size to decrease beyond the point of meaningful statistical analysis in the later stages of the research." Id. at 507-08.

In another publication, the authors revealed the extent of that mortality: the death rate among the radical change group was six times that of the control in the three months preceding the move, and eight times that of the control during

the three months after the move. Bourestom, Pastalon, and Tars, Relocation Report No. 2, Death and Survival 3-4 (Institute of Gerontology, University of Michigan-Wayne State University) (1972?).

Kahn and Kaplan, supra, reported that the patients transferred from Grafton State Hospital were administered two tests prior to their transfer, and the tests were readministered at various times after the transfer to the survivors. Interim Report at 10, 14. The Activities of Daily Living (ADL) test was used "to gain some estimate of the amount of nursing care each patient required for daily activities, such as: meals, personal hygiene, dress, mobility and medication. Three choices of categories were offered: total nursing care, some nursing care and self-care." Id. at 10. In addition, the Brief Psychiatric Rating Scale (BPRS) "was used to gain some estimate of the presence and severity of

psychiatric symptoms. Only three choices were given for each of the 16 symptoms: not present, some and severe." Id. The authors found that 22% of the transferees became worse following the transfer as measured by the ADL scale, and that 35% declined in functioning as measured by the BPRS scale. Id. at 14.

The one factor which appears to have the greatest influence on the mortality risk involved in the transfer of infirm elderly persons is the fate of patient-staff relationships. Uniformly, transfers which have moved the staff with such a population have resulted in dramatically reduced mortality rates as compared with transfers which result in terminating patient-staff relationships. Novick, supra, reported that the relocation of 125 aged patients from an old to a new building at Maimonides Hospital in Montreal resulted in an apparent decrease in

mortality rates. The author attributed the result to three factors: massive preparation of the patients, careful design of the new building with emphasis on meeting the needs of the patients for privacy (almost all received private rooms), and "the preservation of satisfying relationships" among patients and between patients and staff. 41 Hospitals, J.A.H.A. at 70-74.

In a similar study of a move of 96 residents of Vancouver General Hospital in British Columbia from an old to a new wing, Gutman and Herbert, supra, found no increase in the death rate as compared with average death rates in the five years preceding the transfer. 31 J. of Gerontology at 356. Again, relationships among patients and between patients and staff were preserved in spite of the transfer. Id. at 354, 355, 356-57. As was the case in the transfer reported by Novick, Gutman

and Herbert observed a relocation which involved "marked emphasis on physical environment, improved facilities and programs while staff, patient friendship patterns, and geographic location of unit remained essentially constant." Id. at 356-57.

The most dramatic demonstration of the importance of retaining staff and patient relationships resulted from the study of Bourestom and Tars, supra. As indicated above, these investigators studied two moves from county facilities for the aged. The radical change group moved to a private institution, and had to adjust to "a new staff, a new program, a new physical environment, and a new patient population." 14 Gerontologist at 507. The moderate change group moved to an improved physical environment, but "[s]taff and patient groups remained intact as to the nature and structure

of their program." Id. Both groups were compared with non-relocated control groups in a third institution.

> Perhaps the most dramatic finding was a strikingly higher mortality rate for the relocated groups than for their non-relocated counterparts. This effect, however, was noteably greater for the radical-change group than for the moderate-change group. Of the radical-change group, 43% died in the 6 mo. period preceding and the year following relocation compared with the rate of 21% among their controls, a difference which was statistically significant. By contrast, the moderate-change group experienced a 37% death rate compared with a 26% rate among their controls, a difference which could have occurred by chance. . . .
>
> Id. at 508

To similar effect are the conclusions of two other gerontologists:

> Changes in the social environment may have deleterious consequences in terms of psychological well-being and health. Loss of loved ones and loss of familiar objects or surroundings, resulting in helplessness or despair, are related to medical-psychological

> disorders. . . . In general older persons seem to gain satisfaction and support from association with familiar objects and places and from association with persons living in the same environment. . . .
>
> Brand & Smith, Life Adjustment and Relocation of the Elderly, 29 Journal of Gerontology 336 (1974), citations omitted.

Another powerful indication that preserving relationships is critical to survival in a transfer is the fact that investigators of transfers which did not interrupt relationships have found the usual predictors of success and failure unexpectedly upset.

A major study of predictors of mortality among the institutionalized aged was published by Goldfarb, Fisch, and Gerber, Predictors of Mortality in the Institutionalized Aged, 27 Diseases of the Nervous System 21 (1966). The study was not concerned with predictors

of mortality occasioned by relocation per se, but rather explored indicators of mortality risk generally among the subject population. The authors concluded generally that death rates are higher among state hospital patients than among nursing home residents (id. at 22), and that severe cognitive impairment (brain syndrome), physical incapacity, and incontinence were reliable predictors of mortality. Id. at 29. The authors deemed notable the apparent lack of correlation between age or sex and mortality. Id. at 22-23.

Virtually all of the investigators who have published studies of relocation have commented on apparent predictors of relocation survival. Although studies of transfers terminating patient-staff relationships have come to opposite conclusions about age and sex (compare Killian, supra, 15 Social Work at 25 [age does, sex does not, predict relocation mortality] with

Bourestom, Pastalan, and Tars, Relocation Report No. 2, supra, at p. 6 [sex does, age does not, predict relocation mortality]), all investigators who have addressed the question and who have studied transfers without staff have confirmed correlations between relocation mortality and cognitive impairment, physical disability, and incontinence. Aldrich, Personality Factors and Mortality in the Relocation of the Aged, 4 Gerontologist 92 (1964) [cognitive impairment]; Killian, supra, 15 Social Work at 25 [physical disability]; Lieberman, supra, 14 Gerontologist 500 [physical disability and cognitive impairment].

Investigators studying moves which did not interrupt patient-staff relationships found that one or more of the normal predictors of relocation mortality -- physical disability, cognitive impairment, and incontinence -- simply did not work.

Markus, Blenkner, Bloom, and Downs, supra, found ambulation, continence, and organic brain damage apparently unrelated to the survival rates among populations moved without interrupting patient-staff relationships. 27 J. of Gerontology at 379. Gutman and Herbert, supra, found no correlation between survival and mental status prior to transfer, and surprisingly, found the proportion of deaths "greater among ambulatory than among non-ambulatory patients." 31 J. of Gerontology at 356. Kral, Grad, and Berenson, Stress Reactions Resulting from the Relocation of an Aged Population, supra, studied a portion of the population whose transfer Novick described. Kral found, surprisingly, that although none of the psychotic men or women in his subgroup died within the first six months of relocation, 25% of the normal men studied died within that period. 13 Canad. Psychiat. Ass. J. at 205, 208.

It is at least plausible to suggest that physically and mentally impaired patients depend more heavily upon their relationships with staff than do the less impaired patients, for whom other elements of their environment are more critical. Thus a transfer of severely impaired patients who retain their staff involves a subjectively less disruptive alteration of their environment than does a transfer of less impaired patients who also retain their staff. Put otherwise, staff-patient relationships mean more to the impaired, so a change of everything but such relationships is least critical to such patients. This is consistent with Novick, supra, who concluded that preparation of the "mentally confused patients" among his transfer population consisted largely in relying upon "positive cues," which he listed as follows:

> (1) a positive relationship with members of the staff, both paid and volunteer;
>
> (2) a positive relationship with family members;
>
> (3) activities which follow one another in a specific pattern on a daily basis and which are pleasant.
>
> 41 Hospital, J.A.H.A., at 74

In any event, the literature compels the conclusion that the impact of preserving patient-staff relationships can be a matter of life and death for transferred geriatric patients.

Unfortunately, retaining the staff does not necessarily avoid morbidity, although most evidence suggests that a reduced morbidity incident to transfer can be expected. Thus Kral, supra, found that within six months of the relocation described by Novick, 36 of the 54 patients studied by Kral developed symptoms with or without organic signs apparently resulting

from the stress of relocation.

> Of the 13 subjects who presented [organic signs], 6 had infections referable to the respiratory tract. Four of the subjects presented cardiovascular signs (one of them developed a stroke, another had an intraventricular conduction defect and two myocardial infarcts). Three of the subjects had symptoms referable to the eye, and two of these belonged to the group of six subjects with respiratory infections. Two subjects developed dermatitis. Eleven of the 13 subjects developed their organic signs within four months and of these 6 developed them between 2 to 4 weeks after relocation. Three developed the symptoms within the next month; only 1 developed the symptom within the third month and one within the fourth.
>
> 13 Canad. Psychiat. Ass. J. at 204

See also Brody, Kleban, and Moss, supra, 14 Gerontologist at 302 [intra-institutional reorganization produced evidence of severe short-term stress and of persisting effects among some patients].

There is some support in the literature that preparation can reduce the

mortality impact of relocation upon relatively unimpaired geriatric patients. Aldrich and Mendkoff, supra, were unable to measure the effect of "preparatory casework," but indicated that it was [s]ubjectively . . . apparently helpful . . . in reducing mortality." 11 J. Am. Geriatric Society at 192. It bears emphasis, however, that the three-fold increase in mortality observed by Aldrich and Mendkoff (id. at 188) was observed notwithstanding such preparation. See also Blenkner, Environmental Change and the Aging Individual, 7 Gerontologist 101, 104 (1967) [Aldrich and Mendkoff employed "considerable care . . . by a professional social work staff to prepare the older person for the move and to assist in his adjustment to the new place"]. Aldrich explained the higher mortality rate among transferred psychotic patients, and, impliedly, the

apparent failure of preparation as follows:

> [T]he senile psychotic person, although not sufficiently in contact to understand advance explanations of a move, is nevertheless sufficiently aware of familiar environmental cues to become disturbed when the cues are no longer at hand. According to this hypothesis, the senile psychotic individual cannot prepare for a change, and when the change occurs, he lacks the adaptive capacity to cope with it.
>
> Aldrich, supra, 4 Gerontologist at 93

This observation concerning the limited effect of preparation upon cognitively impaired individuals was further developed by Lieberman:

> Psychological preparations such as helping the elderly make decisions about their needs, permitting them some influence on the outcome of their service requests, working with the family, developing programs of trial visits, and the like are among the many strategies practiced by enlightened social agencies. Such a policy is correct not only in its estimation of the human misery involved

> in this transitional stage, but also with regard to the best available evidence on strategies for coping with threat. Yet despite the good sense of psychological preparation, and its firm footing in empirical research on threat, evidence from our research on relocation suggests that it is not a powerful tool in minimizing relocation risk. The reason is not poor practice, but rather incorrect strategy. Relocation is a risk to the individual not because of the symbolic meaning that such transitions imply, but because it entails radical changes in the life space of an individual that require new learning for adaptive purposes. In other words, the cure has been addressed to the wrong problem.
>
> 14 Gerontologist at 497 (emphasis in original)

These observations are confirmed by the experience of Novick. The Maimonides Hospital transfer was preceded by two distinct forms of "preparation," depending upon the characteristics of two groups of the population. The mentally alert portion of the population was prepared through discussion, consultation with respect to

the design of the new facility, and pre-transfer visits to the new site. 41 Hospital, J.A.H.A. at 69-70. With respect to these patients, the preparation addressed the factors expected to address

> the following negative and positive factors in the relocation situation [which] might have a bearing on mortality rate: (1) fear of the unknown, (2) preservation of satisfying relationships, (3) retention of emotionally meaningful possession, and (4) arrangement of space in the building with due regard for the emotional needs of the patients.

Id. at 69

Novick recognized that the "mentally confused patients . . . were not sufficiently in contact with reality to understand advance explanations of the move," and addressed "preparation" to eliminating negative and retaining positive "cues." Novick saw the relative negative cues to relate to the upsetting influence of disturbed patients on each other. Id. at 74.

> Among the positive cues, the following may be listed: (1) a positive relationship with members of the staff, both paid and volunteer; (2) a positive relationship with family members; (3) activities which follow one another in a specific pattern on a daily basis and which are pleasant. Such a stable pattern gives a great feeling of safety to the confused patient.

Id.

The "preparation" of the confused Maimonides patients, therefore, consisted of removing the negative cues by giving the confused patients private rooms, and of reinforcing the positive cues by retaining staff-patient relationships, especially those involving nurse aides and orderlies responsible for the daily care of patients, together with visits from families and preservation of routine in spite of a move to a physically quite different facility. Id.

The relative success of the move studied by Novick, as well as that reported

by Gutman and Herbert, supra, and the moderate change move reported by Bourestom and Tars, supra, is thus attributable to recognition that retaining staff is potentially life saving for all patients, but is especially critical for the cognitively impaired patients whose susceptibility to "preparation" by more abstract means than preserving familiar cues is very low if existent at all.

The apparent failure of even retention of the staff to prevent morbidity incident to a transfer, however, supports Lieberman's conclusion -- addressed to the total impact of a relocation in terms of morbidity as well as mortality:

> Four studies my colleagues and I have conducted over the past years covering 640 individuals (including 175 controls) -- some on healthy elderly moving into affluent, high-care, sophisticated institutions; others involving sick, highly debilitated human beings moving into circumstances that would

> delight a muckracker -- have yielded roughly comparable findings. Namely, no matter what the condition of the individual, the nature of the environment, or the degree of sophisticated preparation, relocation entails a higher than acceptable risk to the large majority of those being moved.
>
> 14 Gerontologist at 495

* * *

APPENDIX 3

On March 20, 1979, Howard Lavin, an administrator of a nursing home in Scappose, Oregon, and a member of an Oregon Task Force to propose rules for the Oregon Health Division regarding nursing homes and other institutions, testified before the Oregon House Aging and Minority Affairs Committee in opposition to HB 2368, a bill which would have required pretransfer hearings for all nursing home residents in Oregon subjected to an involuntary transfer. Mr. Lavin testified in part as follows:

"On a transfer or the discharge of a patient for medical emergency reasons and then reserving the right for that patient to be readmitted: I admit there are some nursing homes fool with this particular proposed rule or law. It's real easy to get rid of a difficult patient in a nursing home, and I'll show you how. If that

patient is costing me too much money per day for one reason or another, I can coerce the physician to transfer that patient to a hospital, fill the bed, and I've kissed the patient goodbye. This is being done. But the correction should be in a rule not in a statute."

STATE OF OREGON)
County of Multnomah) ss.:

I, Gloria M. Bandy, hereby say that I am a Notary Public in and for the State of Oregon, County of Multnomah, and that I prepared the foregoing partial transcription of the testimony of Howard Lavin from a true copy of Oregon House Aging and Minority Affairs Committee Tape No. 18, Side 2, at 657-914 feet, and that said transcription is a complete and accurate transcription of the portion of the testimony it represents.

Gloria M. Bandy

Notary Public for Oregon
My Commission Expires 3/14/80